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INTESTINAL TUBERCULOSIS

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I have chosen a subject, which I am well aware is considered by many, a sanatorium disease, and of rare occurrence in family practice and general surgery. I am convinced, however, that many more cases of intestinal tuberculosis are seen in private practice than are available for statistics, possibly many that are not recognized.

It would also appear from my own experience and from contributions in the literature that there is room for considerable improvement in the treatment of these patients. In recent years there have been advances in the treatment of tuberculous lesions of the intestines comparable with the results of surgical treatment of pulmonary tuberculosis.

Intestinal tuberculosis may be divided into two main groups: 1. Primary, or the rare type of disease characterized by a hyperplasia of the wall of the intestine. In these cases active disease rarely is found in the body. 2. Secondary, or the ulcerative lesions of the intestines, which in practically all cases is a complication of active pulmonary disease. Many writers who have studied the pathology of tuberculosis are skeptical of the existence of primary disease of the intestines except in children. Over 50% of all children and about 90% of all adults have tubercular infections at some time in their lives. An intestinal lesion may well have its origin in arrested disease in the lungs, lymph nodes or elsewhere.

There is still considerable discussion regarding the transmission of the tubercle bacilli to the site of the initial lesion in the intestine. The weight of opinion appears to be in favor of ingestion although there is considerable evidence that in many cases the infection is carried in the blood stream from a ruptured cavity in the lungs or from lymph nodes. The fact that primary intestinal tuberculosis occurs in 34%[1] of the cases in the British Isles where much of the milk is tuberculous, favors the ingestion theory.

Read before the Providence Medical Association, May 3, 1937.

The initial lesion in most cases of intestinal tuberculosis is in the terminal ileum and caecum. It may spread upward from the original focus involving the small intestine or downward in the colon and rectum where the hyperplastic type is more frequent. In the ulcerative type of disease the earliest tubercles are found in the Peyer's patches and solitary follicles, which break down, forming ulcers. These may penetrate the wall of the peritoneum but rarely perforate. The ulcers may progress along the intestines or encircle the mucosa, girdle ulcers. Healing of a girdle ulcer may result in a fibrotic ring with resulting obstruction. The hyperplastic variety is characterized by the formation of granulation tissue in the submucous and subserous layers. This results in a marked thickening of the intestinal wall, more frequently the terminal ileum and caecum. The mucosa is not involved as a rule but is gradually pushed into lumen resulting in constriction.

I have been unable to find any statistics of the incidence of intestinal tuberculosis. Mortality statistics of the Massachusetts State Board of Health[2] group tuberculous peritonitis, mesenteric glands and intestinal tuberculosis together. In these three groups there were 2,501 deaths from 1912 to 1935 inclusive. The highest number 202, occurred in 1916 and the lowest 31 in 1934. In the United States there was an average of 2,200 deaths from these three diseases from 1930 to 1932 inclusive, which dropped to 1,431 in 1935. It is evident that either the widespread campaign against tuberculosis or improved methods of treatment is saving many lives.

Since 1900 at the Massachusetts General Hospital there have been 195 cases diagnosed intestinal tuberculosis, 9 with tuberculosis of the appendix, 52 patients having rectal tuberculosis and 24 with tuberculosis of the anus. At the Lakeville Sanatorium, we have had 39 patients with tubercular lesions of the intestines. This small number is to be explained by the fact that we treat no patients with active pulmonary diseases in which ulcerative intestinal lesions occur as a complication. During the same interval at Lakeville, we have seen 82 patients with mesenteric glands, and 133 cases with tubercular peritonitis.

The most extended study of intestinal lesions complicating pulmonary tuberculosis was carried out by Brown and Sampson.[3] In a routine X-ray examination of the gastro-intestinal tract of 1,801 patients they found 8% had intestinal lesions.

Intestinal tuberculosis is characterized by a very insidious onset and unless the significance of the early symptoms is recognized the most favorable time for treatment is past before a diagnosis is made. Loss of appetite, indigestion, indefinite abdominal pains, constipation and loss of weight are characteristic of the early case. The X-ray examination is frequently inconclusive at this stage.

As the disease progresses, nausea and vomiting occur, abdominal pain becomes more acute especially after eating and is frequently more severe in the right lower quadrant, diarrhea alternating with constipation may occur, the loss of weight is more marked and an unexplained fever is observed. These symptoms are frequently considered an indication for an exploration, when the correct diagnosis may be made or suspected and an unoffending appendix removed.

The most frequent complication in the later stages of intestinal tuberculosis is obstruction. It is of rare occurrence in the ulcerative lesions, since in this type it is caused by healing of a girdle ulcer in the form of a fibrotic band or stricture or adhesion of loops of intestine resulting in angulations. In the hyperplastic type of disease, symptoms of obstruction are common owing to the great increase in thickness of the intestinal wall and gradual narrowing of the lumen. Perforation occurs in a small percentage of cases resulting in a walled off abscess, external fistulae or diffuse peritonitis. Intestinal perforation as a terminal complication occurs in 3% of patients who succumb to pulmonary disease. Ulcerative lesions may involve the colon in rare instances resulting in symptoms very similar to ulcerative colitis except for the presence of tubercle bacilli in the stools. We have seen four cases of this type at Lakeville.

Cancer, regional ileitis, ulcerative colitis and non-specific granulomas are the most common diseases to be differentiated from intestinal tuberculosis. Cancer occurs in older people as a rule, where tuberculosis is more common in patients under forty. Blood in the stools is more common in cancer, emanciation and anaemia are more pronounced. Regional ileitis is characterized in its early course by symptoms of obstruction; ulceration, perforation, abscess and fistulae are late manifestations. Intractable diarrhea, characteristic stools and prostration help to distinguish ulcerative colitis. The X-ray study is of considerable help. Non-specific granulomas are frequently mistaken for hyperplastic tuberculosis in the gross specimen. The histologic picture is difficult to differentiate. Wilensky and Moschcowitz[4] of Mount Sinai have stated that many cases of hyperplastic tuberculosis have been incorrectly diagnosed by pathologists. At present the field of surgery is limited to the relief of intestinal obstruction, removal of the rare tuberculous appendix and exclusion or in rare cases excision of hyperplastic disease, usually of the terminal ileum or caecum.

Heliotherapy and ultra-violet have brightened the outlook for the patient with intestinal tuberculosis, similar to the results of surgery in pulmonary tuberculosis. Brown and Sampson reported a series of 271 patients treated by ultra-violet with good results in 73%. The interesting fact about their cases was that healing of the intestinal lesion was frequently observed in the presence of progressive and even fatal pulmonary disease. Other writers have reported similar results. Our cases at Lakeville are not given the intensive ultra-violet treatments advocated by Brown and Sampson. We are not convinced as yet that the best results are attained by the deep pigmentation of the skin resulting from the Saranac method. We are giving treatments three times a week and feel that better results are attained by less tanning of the skin. Our cases differ from those that occur in most tubercular sanatoria in that we have none with active pulmonary disease. If the disease is not too advanced complete arrest or marked relief of the symptoms after ultra-violet treatment with the usual sanatorium care results in a high percentage of our cases.

Pneumoperitoneum has been of great benefit in cases of tubercular peritonitis and has been advocated by some recent writers for intestinal tuberculosis. Salkin[5] of Michigan State Sanitorium states that it has been proven of benefit in all moderate cases of intestinal tuberculosis and in 80% of severe cases. He has treated 95 cases with pneumoperitoneum with complete symptomatic relief in 73%. This method may replace ultra-violet and heliotherapy, but as yet we feel that it is still in the experimental stage.

Considerable emphasis has been placed by some writers upon the value of vitamins and low residue diet in tuberculous enteritis. They are of unques-

tioned value in cases with intractable diarrhea and intolerance to the usual diet. Few writers favor this method for all patients with intestinal tuberculosis but prefer a generous well-balanced diet. At Lakeville we are adding cod liver oil and tomato juice to the regular diet in many cases.

A small number of patients with intestinal tuberculosis develop intestinal obstruction and surgery is imperative. The cause of the obstruction can then be determined and at the same time relief obtained by ananastomosis or external drainage. A unilateral or bilateral exclusion of the diseased segment with anastomosis or enterostomy is all that can be done in many advanced cases. Santy[6] reported a series of 20 cases in which primary resection was done in half and an exclusion done in the others. His results were much better in the cases with exclusion. Ultraviolet and heliotherapy were used following the exclusion operation and were found to be of marked benefit after the diseased bowel had been put at rest. Santy advised secondary excision after all benefit from conservative treatment has been obtained and the local disease is not arrested.

Tuberculosis of the appendix deserves mention as in most cases there is a rather prolonged history suggesting pathology in the right lower quadrant. It is also of interest that Archibald[7] and other writers since his first report have noted that removal of the appendix alone in cases of very advanced ileocaecal disease resulted in marked relif from pain.

I am not going to bore you with detailed records of a large number of cases. I would like to cite briefly a few cases that illustrate certain types of disease.

Case Histories

124. Mrs. A. Age 40. December 11, 1917. Patient had pulmonary tuberculosis and had been in a sanatorium, is now six months pregnant. Has increasing constipation for 6 weeks with no movement for past 5 days. Usual symptoms of acute obstruction.

Operation: Several loops of small intestine matted together. Enterostomy, miscarriage 12 hours later. 2½ months afterward, resection of 6 inches ileum and end to end anastomosis. Recovery. 1937 condition excellent.

1381. Mr. S. Age 39. July 20, 1922. A history of general abdominal pain, indigestion and attacks of severe constipation, vomiting and loss of weight for past five years. Complete obstruction for 3 days. Had no pulmonary lesion but had complete transposition of viscera.

Operation: Enterostomtomy. Death. At post mortem, hyperplastic ileocaecal tuberculosis.

2642. Mr. McQ. Age 46. March 5, 1925. General abdominal pain, indigestion without food relief and frequent attacks of severe pain with loss of strength for 5 years.

Operation: Exploratory. Hyperplastic ileocaecal tuberculosis, about 15 annular strictures in ileum and numerous mesenteric glands. Ileostomy. Death in 1927 in tubercular sanatorium.

Lakeville Patients:

1. F. C. female; age 28, admitted January 14, 1937.

Operation at Salem, August 1933, appendectomy followed by fecal fistula. Operation December 1933, repair of fecal fistula. Operation July 1936, M.G.H. colostomy, transverse colon and repair of fecal fistula in recto-sigmoid. Fecal fistula persisted, urinary fistula developed. Guinea pig positive. Now has large firm tumor in right lower quadrant extending into pelvis, involving bladder. Colostomy; fecal and urinary fistulae left lower quadrant.

2. L. R. colored, age 21. Admitted April 1936.

Tuberculosis of 9, 10, 11 dorsal vertebrae. X-ray diagnosis Weymouth Hospital "almost complete obstruction of ileum from old appendix abscess or tubercular peritonitis." Operation, June 1936. Arthrodesis of the spine. Abdominal pain, attacks of vomiting. Operation, October 1936: Resection of caecum and ileum for hyperplastic tuberculosis.

3. E. J. S. female, age 7. Admitted October 1935.

Raw milk at school. Abdomen distended February 1935. Abdominal pain, convulsions. Treated at Children's Hospital, Boston, for mesenteric adenitis. Developed diarrhea and vomiting. Stools positive and gastric lavage positive for tuberculosis. Still has abdominal pain and distention, vomiting and diarrhea. Improving under ultra-violet, tomato juice and cod liver oil.

Summary

The initial lesion of intestinal tuberculosis whether ulcerative or hyperplastic in most cases is in the terminal ileum and acecum. Eight per cent of patients with pulmonary disease have terminal perforations. The onset of intestinal tuberculosis is insidious, the early symptoms are gastric disturbance, abdominal pain, constipation and diarrhea. Pneumoperitoneum has given favorable results but has not been extensively used. Vitamins may be of benefit. Heliotherapy, ultra-violet and conservative surgery appear to give better results than radical excisions except in selected cases.

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Discussion

Dr. Edwin D. Gardner, New Bedford, Mass.: I think we all agree that Dr. Moore has read a very comprehensive paper. I cannot argue with him because in the first place there is no argument and in the second place, having worked only in a general hospital, I have seen comparatively few cases of intestinal tuberculosis. Undoubtedly, Lakeville Sanatorium has done very good work in intestinal tuberculosis and almost surely has reduced the mortality in abdominal tuberculosis in Massachusetts from 202 deaths in 1916 to 33 deaths in 1935. I think Dr. Moore should be congratulated.

I should like to speculate somewhat on another phase of this subject which may or may not pertain to intestinal tuberculosis.

About 1919 I began to see many cases with the following findings: A child or a young adult, sometimes and sometimes not with a history of a common cold about two weeks previously, comes into the hospital with the story that 5-6 hours to 24-48 hours before entrance, he began to have constant abdominal pain, either in the right lower quadrant or the epigastrium or about the umbilicus. This has persisted and is usually accompanied by nausea and vomiting. Occasionally there is a history of diarrhœa, but usually not. Ordinarily this is the whole history. On examination there is tenderness over MacBurney's point, very little if any spasm. Otherwise the physical examination is negative. Sometimes the white count is elevated and sometimes not. The temperature is usually slightly elevated, rarely up to 101 or 102. Pulse and respirations are not remarkable. The urine is negative. It has been my practice to operate on those cases if the temperature is not too high for the other signs, if the white count is elevated, and particularly if there is definite spasm. Sometimes I find definite acute appendicitis, which is the reason for operating. Frequently, however, I find many enlarged and edematous glands in the mesentery of the terminal ileum, some congestion of the terminal ileum, and possibly the cæcum and appendix. Occasionally there is some thickening of the terminal ileum, but usually not. Usually there is considerable free, straw-colored, clear, odorless fluid and nothing more. Of course, the appendix is removed and the convalescence is uninterrupted. The follow-up has shown nothing. Of course, maybe if the follow-up could be continued long enough something would be uncovered. I do not know.

What are these cases? What shall be done about them? Surely such radical surgery as resection is out of the question. Are they the forerunners of so-called regional ileitis, or are they early cases of tuberculous enteritis? At one time I wondered if the influenza epidemic of 1918-1919 was the cause of these cases. Should all of these cases receive the general care that we give tubercular cases?

Another thing I should like to ask Dr. Moore is, how he differentiates betwen so-called regional ileitis and tuberculosis of the ileum? I use the words so-called because as I understand it, the so-called "regional ileitis" can occur in any part of the ileum or jejunem or even in the colon.

So far as I know, the symptoms and outcome of both of these conditions are identical. Some of both apparently get well spontaneously, and some go on to intestinal obstruction and fistular formation. Those cases that come to operation or autopsy, show marked fibrosis and both even have marked giant cell formation. Of course, if typical tubercles and tubercle bacilli are found the diagnosis is easy, but it is not always easy to find tubercle bacilli, even if they are present.

I frequently wonder if both of these diseases have not a tubercular foundation.

I wish to thank Dr. Moore for his very excellent paper and the members of this society for giving me the privilege of discussing it.

THE TREATMENT OF CANCER OF THE CERVIX UTERI AT THE RHODE ISLAND HOSPITAL. 293 CASES WITH 5 YEAR FOLLOW-UP

Herman C. Pitts, M.D., F.A.C.S., and George W. Waterman, M.D., F.A.C.S.

After discussing briefly the methods of treating cancer of the cervix in different clinics here and abroad and the rationale of the various methods, the authors describe their method used at the Rhode Island Hospital, and review their results in a series of 120 cases treated from 1921 through 1925, where the *older* method of surface and intracaviteal radiation with 25 mgm. and 50 mgm. silver and brass filtered capsules and occasional use of short steel filtered 5 mgm. needles interstitially, was in use, as against their results in a series of 173 cases treated from 1926 through 1930, where the use of long needles of low intensity and platinum filtration (.5 mm.) interstitially in cervix and paramet-

Author's Abstract of a paper published in Surgery, Gynecology & Obstetrics, January, 1937, p. 30.

rium combined with the use of a 20 mgm. capsule in the cavity was used. Their results as summarized are given as follows:

Survived 5 years	79 of 293 cases 1921-1930	26.9%
Survived 5 years	24 of 120 cases 1921-1925 (by older method)	20.0%
Survived 5 years	55 of 173 cases 1926-1930 (by newer method)	31.7%

The authors have broken down the figures of the last 5 years to show the effect of an increase in the time interval of treatment as follows:

1926-1928, when interval was 72-96 hours and total dosage 3000-5000 mgm. hours, the survival rate was 27:96 or 28.1%.

1929-30 when the interval was raised to 144-168 hours or 6000-10000 mgm. hours, the survival rate was 28:77 or 36.3%.

The authors have likewise given tables in which the extent of involvement when first seen is shown, cases coming early with small lesions being put in the Stage I group; those with more advanced lesions but still limited to the cervix being in Stage II; and the more advanced lesions with involvement beyond the cervix being in Stage III. Finally the complete involvement of the pelvis with large masses filling both sides (frozen pelvis) is put in Stage IV.

They find a marked and to them significant improvement in the Stage III cases, i. e. those with definite parametrial involvement or extension beyond the cervix, as follows:

Period 1921-1925 — Stage III — older method 6:43 or 14% survived the five year period and 3 of these died in the 6th year so that only 3:43 or 6.9% survived 6 years after treatment.

Period 1925-1930 — Stage III — new method 18:62 or 29% survived for five years and 17:62 or 27.4% alive 6 years.

In order to show that their method of placing long platinum needles into the parametrium is not dangerous, i. e. does not carry a high mortality from peritonitis and infection and a high morbidity with fistula formation, the authors have given their figures as to immediate mortality and fistula formation and find no increase. In fact their incidence of fistulas has been less under the new method.

The authors conclude that in their hands the use of long platinum filtered needles for a single treatment of long time interval with wide distribution of the small foci of radiation has brought about a marked improvement in their results as judged by the 5 year survival criteria.

DERMATORRHEXIS

WITH DERMATOCHALASIS AND ARTHROCHALASIS (THE SO-CALLED EHLERS-DANLOS SYNDROME)

F. RONCHESE, M.D.
PROVIDENCE, R. I.

Parts of the syndroms described by Ronchese under this new title have been reported under various denominations, viz., dermatolysis, cutis laxa, cutis hyperelastica, loose skin, india rubber skin, etc., none of them satisfactory. The syndrome consists of three symptoms: (1) pronounced fragility of the skin and its blood vessels, with breaking, splitting and the formation of hematomas and pseudotumors subsequent to the slightest trauma (dermatorrhexis-fragilitas cutis), (2) a more or less pronounced hyperlaxity and hyperelasticity of the skin (dermatochalasis-laxitas cutis) and (3) more or less pronounced hyperlaxity or hyperflexibility of the joints (arthrochalasis-laxitas articularis). Obviously the main feature of the syndrome is the fragility of the skin with the consequence of disfiguring scars. This is the reason for naming the whole syndrome from the main symptom. Particularly in this country little attention has been paid to this syndrome by dermatologists, pediatricians and orthopedic surgeons.

Three cases from the Department of Dermatology of the Rhode Island Hospital are described. The syndrome does not seem to be so extremely rare as many authors maintain. After the experience of the first two cases, the third was immediately diagnosed by the admitting physicians. Twenty-seven cases have been reported in the literature; only one in the American literature. The syndrome is well defined and constitutes a clinical entity to be included in the group of congenital dystrophic anomalies. The etiology and pathology are obscure.

Designation of syndromes by proper names is discouraged. However, F. P. Weber (Br. J. Derm. 48: 609, Dec. 1936), while highly praising Ronchese's paper, prefers the heading "Ehlers-Danlos Syndrome."

From the Department of Dermatology, the Rhode Island Hospital.

Résumé of a paper printed in the *American Journal of Diseases of Children*, 51, 1403, June, 1936.

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Medical Library Building
106 Francis Street, Providence, R. I.

IT CAN HAPPEN HERE

One of the tragic sights which the physician sees all too frequently is an individual who has unknowingly been deceived, misdiagnosed, and ill-treated by an ignorant individual posing as a trained man under the title of chiropractor. And it is particularly pathetic when the legislators of his State not only sanction this man who may have been trained by a correspondence course, but even appear ready and willing to champion him. This backing has been obtained in Rhode Island by the great American trick of maintaining a good lobby and a lot of baloney. By the former the chiropractors have succeeded in preventing the passage of a Basic Science Law, a bill which every medical man admits is minimal in its requirements and by the latter they attempt to obtain a good name before the public. So far they have been successful in at least some respects. But, as Al Smith has said—"Let's look at the record."

A chiropractor recently had the audacity to advertise in a Providence newspaper to the effect that he was "just from New York". It is presumed that this important point would help to fill his office. But he does not tell the whole truth. For he was forced to leave that metropolis by the passage of a law denying those of his ilk the right to practice the healing art!

"And look at this." A case which involved the testimony of a chiropractor recently came before the Supreme Court of Ohio. The learned justices of this sovereign state proclaimed once and for all that chiropractors do not practice a healing art, and ruled out that testimony.

So there is the handwriting on the wall. What can be done about it in Rhode Island? What can you as a physician do to eliminate these parasites from our midst? The answer is straightforward and simple. First, join the Rhode Island Medical Society if you are not already a member. There is weight in numbers; an opinion expressed by the whole medical body of this State must mean something! Next is to insist on an expression of that opinion. And that is to be done, not by just a motion passed in meeting, not just by a speech at a legislative hearing, but by a good, active, well-paid lobby. We as a Society do not need to indulge in baloney for we have the truth. But we should employ a lobby as good or better than the quacks, and make that truth known and understood by every legislator on the hill.

So with the results of New York and Ohio already recorded, let us unite in adding the name of Rhode Island to the roll. It can happen here!

STREET LIGHTING

During the year 1933, in the normal hours of darkness, 324,610 automobile accidents resulted in 16,230 deaths and 381,540 personal injuries in the United States.

The statistics show that

1. The rate of death per accident is much greater at night.
2. Most pedestrian fatalities occur at night.
3. Night fatal accidents are doubled in winter (dark) versus summer (light) months.
4. Main highway and rural fatalities are increasing.
5. Night-time accidents and fatalities are increasing at a faster rate than day fatalities.

Why? The provisions for street lighting have

not kept pace with other expenditures. There is really only one vitally important difference between day-time and night driving. The car is unchanged; the roadway has the same surface and is just as wide and winding; the miles are of the same length; and the towns are just as far apart. There is usually less traffic at night and this has some bearing; but the chief difference is our ability to see for long distances by day as compared with our limited range of vision by night.

Then there is that reaper of death, glare from improperly adjusted headlights. Who hasn't encountered glaring headlights at night? We have all experienced the sensation of taking one last look at the road ahead, setting the steering wheel where the road should be, and praying that we don't get hit, hit someone else, or end up in the ditch. But why are improperly adjusted headlights glaring at night? They certainly aren't in the day-time. Simply because of the extreme contrast between these bright sources of light and the surroundings adequate highway illumination will destroy this contrast. There is no glare of headlights in the whiteway districts of our larger centers.

Ordinarily, in driving, the pupil of the eye is wide open to allow as much light as possible to enter the eye. As the glaring headlights approach, there is an immediate contraction of the pupil to a very small opening to keep out the glare. Then the glare passes. However, the pupil of the eye opens more slowly than it closes. For every second during which the pupil is contracting, it requires approximately one minute of expansion for the vision to be adjusted to give the same seeing ability on the road after the glaring headlights have passed. These are the reasons for our temporary loss of visibility. Is it any wonder that many pedestrians are seen too late? Proper illumination of the roadways would permit of driving with depressed headlight beams and less powerful headlights, eliminating this extreme contrast and glare.

If all night traffic accidents could be eliminated, the economic saving each year would pay the salries of all the teachers, supervisors, and principals of all the elementary and secondary schools in this country. In addition, the lives of 15,000 people would be saved each year—a number equal to more than one-fourth of all Americans killed during the entire World War.

RHODE ISLAND MEDICAL SOCIETY

Minutes of the One Hundred and Twenty-sixth Annual Sessions

Meeting of the House of Delegates

(Continued from Page 120)

Report of the Committee on Public Health Clinics

During the year, your Committee has continued its efforts to obviate conflicts between the private practice of medicine and other agencies concerned with health. The Chairman has continued his contact with the nursing agencies and has attended their conference. It is felt that the interchange of viewpoints has been decidedly helpful and that definite progress is being made.

Early in the year the Committee met and drew up an outline to be followed in the event any group of physicians in a given locality desired to emulate the policies and procedures of the East Providence Physicians' Association or the Caduceus Club. A copy of the outline is appended and made a part of this report.

The Chairman was invited to discuss the outline before the Woonsocket Medical Society and the plan is now under consideration there. An invitation to present a similar paper in Westerly came at an unfortunate time and could not be taken advantage of. It is hoped that a similar opportunity will again present itself.

A special meeting of the Committee was held on February 11, 1937, to consider complaints received from roentgenologists regarding the X-ray department of the Providence Tuberculosis League. It was brought out at the meeting that the League is a body supported to a large extent by grants from the Community Chest and therefore is a charitable agency; but that it has recently extended or attempted to extend its field of diagnosis to groups of food handlers and others. The extension of this service was discussed at length by all present and it was admitted by Dr. John Pinckney, representing the League, that the sort of X-ray examination that was given by his department was not equal to the minimum standard set by private roentgenologists. Dr. I. Gerber stated that he did not consider the examination by the League method to be adequate. Dr. Pinckney admitted that it was not, and further stated that he considered that the health of Provi-

dence citizens as regarded tuberculosis was his responsibility. The Chairman pointed out that this is an unwarranted assumption of responsibility and commented that such responsibility belongs to the entire medical profession and not to any lay or welfare organization.

The Committee is on record as believing that the health of the community is the responsibility of its physicians. Today, with advancing knowledge through lectures, newspapers and radio, the League could better reserve by using its position to direct public attention to the need for complete and regular checkups with the family physician and to serve only the indigent properly referred to it.

The physician who refers and the clinic which accepts a patient who should be in the office of a private physician definitely harms the rest of the profession and is aiding and abetting the clinical abuse which your Committee is trying hard to correct. When a specialist in internal medicine sees a patient in his private office and charges a fee of $5.00 or at times $10.00 in the same family, and then refers that family for X-rays to the Providence Tuberculosis League instead of to a reputable fellow practitioner specializing in roentgenology — then no wonder we find the "Clinic Problem" so vexing. If we are to be faced with contract practice and extension of welfare service to the detriment of private practice, some attempt should be made at present to correct this evil before it is well established. As a result of your Committee's activity there has been a definite crystallization of opinion among the roentgenologists and proper steps are being taken to meet and to solve similar problems.

Again your Committee urges the formation of medical groups either within or without the regular medical associations for the discussion and solution by group action of the many medico- and socio-economic problems that beset us today. The Chairman was also invited to discuss such group action before the Kent County Medical Society. The members are at present examining the feasibility of the plan for their needs.

In closing, the Committee again offers its assistance to any individual or group within the profession for the elimination of conflicts with private practice.

Respectfully submitted,

CHARLES L. FARRELL, M.D., *Chairman.*

Suggested Outline for Formation of Medico-Economic Group

All local physicians to meet and agree that their interests are best served by agreeing to the following principles:

1. The health of the community is the responsibility of the physicians and this responsibility is best met by a uniform attitude among the physicians, both toward each other and toward the health and welfare agents in their locality.

2. The attitude of every physician to the health problem should be uniform and be formulated as a result of a free and frank discussion of each individual's ideas as to what constitutes the best plan for united thought and action.

3. Assume the leadership in instituting public health instruction and public cooperation in disease prevention.

4. Deputize one or two members to act as a committee to investigate and correct situations inimical to the prerogatives and privileges of the physicians in private practice.

5. Study the needs of the community and officially authorize one or more members to represent the physicians in contacting the proper parties and to assist in correcting the defects or abuses under consideration.

6. Notify all health and welfare agencies of the district that in initiating any program of health or welfare activity involving the free services of physicians that the medical profession of the district must first be interviewed and their attitude considered before proceeding with the project.

7. Arrange with the health unit of the State Department of Health to cooperate in its work and to enlist its support and influence to promote a better community understanding of the physician's place in the scheme of things in his locality.

8. Standardize the forms of medical practice as regards preventive medicine—prenatal care, infant care, care of the pre-school child—as well as refer work—tonsillectomy, X-ray, surgery, and tuberculosis cases.

9. Agree on uniform attitude toward fraternal, society and contract practice, industrial accident care and food handlers examinations.

10. Agree among each other to accept no clinical work or to give free services to any group for any purpose whatever, no matter how worthy, until the plan has been put before all the physicians, meeting as a group, and analyzed as to its need and desirability.

11. Emphasize the attitude that the profession stands ready at all times to give its free and active support in any situation for human betterment when it has a voice in the direction and extent of the work and is certain that such work does not encroach on the rights and prerogatives of the family physician.

Technique for Application of the Above Suggestions

1. Hold a meeting and officially form a medical group with nominal dues for stationery, postage, telephone calls, etc. Draw up by-laws; may use example of Caduceus Club.

2. Agree to meet and discuss all medico-economic and medico-social problems and agree to be bound by the will of the majority.

3. Work for a school physician and formulate a plan of action for the said school physician acceptable to all, define and limit his duties and have him refer all defects to the family physician for correction and not to a clinic.

4. Cooperate with District Nursing Association in defining and limiting the duties and activities of nurses, specify that no nurse shall visit a patient more than once without contacting the doctor on the case and then to limit her activities to his specific orders. In the event that a district nurse discovers a case not under the care of a physician, that she may revisit once in order to insist on medical care but not to continue such visits without authorization from some physician. In no case is a nurse to give an enema, eye wash, or apply any medications without written orders of a physician. In no case is a nurse to refer a patient to a specific doctor and she is never to refer to a clinic. Nurses should not arrange for clinic care, even on request of the patient or an organization, unless requested to do so by a physician.

5. Interview school officials and work for regulations requiring pre-school examination of all children entering school for the first time; this work to be done by the family physician and not as a clinic activity. Give informal talks before parent-teacher associations on health subjects and child guidance. Enlist their cooperation but do not fall in with schemes proposed by groups using the free services of physicians in school clinics attended by children who should be visiting their family physician.

6. Self explanatory.

7. In an effort to prevent State Medicine and the taking over by the State of smallpox vaccination and diphtheria immunization it is essential that local physicians make some provision for doing this work, either in their offices or as a public health measure. The technique can be varied for the needs of individual localities. The Pawtucket plan could be used if desired.

8. Agree on routine procedures in certain cases; routine urine and blood pressures in prenatal monthly, monthly examinations of infants from birth to six months at which time formulae are modified, at the sixth month routine vaccination and immunization against diphtheria, tuberculin testing, thorough physical examinations of pre-school children and follow-up to check defect. Such procedures will eliminate clinics for the above and prevent State encroachment on private practice.

9. Agree not to enter into contract practice detrimental to the public and other physicians, or to agree to render service under conditions which make it impossible to render adequate service to the patient or which interfere with reasonable competition among fellow physicians. Very soon persons representing insurance companies will attempt to sign up physicians to care for insured persons at a rate less than usual and to direct all such insured persons to one particular physician. Such schemes are detrimental and are bound to fail if all physicians turn them down. Agree not to issue certificates of health to food handlers without a physical examination including smear and Wassermann. Forms may be mimeographed and distributed to all physicians so that issuance may be uniform.

10. If approached to examine a group of Boy Scouts or to examine a group of pre-school children, defer action until the matter has been thrashed out pro and con before the medical group and a plan of action agreed upon.

In the event that 100 per cent cooperation between physicians cannot be obtained, it is suggested that you go ahead with the plan as outlined as best you can; then those physicians not cooperating will be free lances and while they as such are free to engage in practices not approved by the majority, they will soon tire of thus disposing of their services. The fact is that physicians outside of a medical group seldom are a big factor in the medico-economic life for many years and are usually not sought after by philanthropic agencies. Newcomers in the medical field should be received warmly and every effort made to mould their opinion and activities for the best interest of all physicians in the locality.

A united medical profession cannot be exploited and such a union keeps otherwise recalcitrant members in line.

Report of the Committee on Education

1. As in the past two years, popular health talks were given under the auspices of the R. I. Medical Society. The meetings were held on Sunday afternoons during the months of November and March at the Medical Society.

2. There were nine lectures given and fourteen speakers addressed the lay public. The following subjects were discussed:

"Common Diseases of the Skin."
"The Care of the Infant and Diseases of Childhood."
"Why People Misbehave."
"Facts and Fancies About Arthritis."
"Diseases of the Eye, Ear, Nose, and Throat."
"Cancer—Facts and Fancies."
"Headache—Medical and Surgical Aspects."
"How to Grow Old Gracefully."
"Why Poison Yourself?—The Nostrum Evil."
"Modern Trends in Obstetrics."

3. The meetings were well attended, extra chairs were necessary and the balcony required to seat the enthusiastic audience. The informal question period was well received.

4. Publicity was extensively employed to stimulate interest in the meetings. The *Providence Journal* and *Evening Bulletin* generously published photographs of the speakers, announced the meetings and printed a splendid abstract of the individual lectures. A large amount of our paid advertising was made possible through the generosity and courtesy of Blanding & Blanding, Inc.

5. The speakers made every attempt to acquaint the public with advancements in medical science, to encourage an optimistic attitude toward disease and to dispell fear; they stressed the importance of early diagnosis, the importance of the family physician, and gave considerable thought to preventive medicine. The subjects were presented in a manner to be easily understood by the average layman.

As the Sunday meetings are attended chiefly by the lay public of Providence, it seems advisable for the county societies to sponsor a similar educational program and to function independently of the State Society. It is doubtful whether the Providence meetings can ever adequately cover the entire State. The committee suggests that the County Societies seriously consider such a plan.

Respectfully submitted,

RUSSELL S. BRAY, M.D., *Chairman.*

Books Given by Dr. John E. Donley for the Davenport Collection

A PHYSICIAN'S ANTHOLOGY OF ENGLISH AND AMERICAN POETRY. Selected and arranged by Casey A. Wood and Fielding H. Garrison.

THOMAS LINACRE. By William Osler.

COUNSELS AND IDEALS FROM THE WRITINGS OF WILLIAM OSLER.

ARABIAN MEDICINE AND ITS INFLUENCE ON THE MIDDLE AGES. 2 volumes. By Donald Campbell.

THE LIFE OF EDWARD JENNER. By F. Dawtrey Drewitt.

THE LIFE AND CONVICTIONS OF WILLIAM SIDNEY THAYER. By Edith G. Reid.

SURGICAL MEMOIRS AND OTHER ESSAYS. By James G. Mumford.

THE CENTURY OF COLUMBUS. By James J. Walsh.

OLD MASTERPIECES IN SURGERY. By Alfred Brown.

THE HISTORY OF ST. BARTHOLOMEW'S HOSPITAL. 2 volumes. By Norman Moore.

Report of the Trustees of the Medical Library Building

Only one meeting of the Trustees of the Building was held before the death of our Chairman, Dr. James W. Leech. At that meeting it was decided to purchase new shades for the Hall and also for the Reading Room. There have been no further meetings.

Respectfully submitted,

EDWARD S. BRACKETT, M.D.

Report of the Publication Committee

Dr. F. N. Brown resigned as Editor on January 1st, 1937. Dr. A. H. Miller was appointed Managing Editor on that date. Dr. C. W. Skelton was continued as Business Manager. As Associate Editors the following were appointed: Drs. William P. Buffum, Alex. M. Burgess, Francis H. Chafee, Henri E. Gauthier, John C. Ham, Thad. A. Krolicki, Edward V. Murphy, Malford W. Thewlis, George L. Young. More pages of reading matter have been published and at less cost.

Respectfully submitted,

LUCIUS C. KINGMAN, *Chairman.*

Report of the Committee on Emergency Medical Relief

Dr. Charles F. Gormly, Chairman of the Committee on Emergency Medical Relief, submits the following report of the Medical Director of the State Unemployment Relief Commission:

Dear Mr. Gormly:

The following is a report of my activities as Medical Director of the State Unemployment Relief Commission. To my office in the State Office Building come requisitions for hospitalization, confinement care, various surgical and medical appliances, special prescriptions, glasses, dental treatment, X-rays, and doctor's bills for adjustment, where the charges are not strictly in accord with the Medical Plan. These are sent in by the Case Work Supervisors in the various districts throughout the State and authorizations are sent to them. All of these requisitions and copies of the authorizations, with the aid of my secretary, Miss Sevigny, are filed for ready reference, as well as copies of the examinations of men and women to determine their eligibility to work on State Unemployment Relief.

Since December, 1935, authorizations for hospitalization at $2.00 per day were sent to the Rhode Island, St. Joseph's, Miriam, Charles V. Chapin, Notre Dame, Memorial, Woonsocket, and Westerly Hospitals to the number of 762. Authorizations for confinement care at $2.00 per day were sent to the Providence Lying-In Hospital numbering 167 and to various other hospitals, including St. Joseph's, Homeopathic, Memorial, Miriam, and Woonsocket Hospitals, to the number of 58.

Authorizations for confinement care by doctors in homes were sent to the number of 109, for an average fee of $25.00. Authorization for surgical appliances as abdominal belts, trusses, special corsets, back braces, special shoes, arch supports, caliper braces, splints, etc., to a total cost of $2,421.22. Authorizations for special prescriptions were provided at a total cost of $72.40. Authorizations for eye glasses were furnished for 1,040 clients to a total cost of $4,504.55 or an average cost of $4.33 per pair. Authorizations for dental treatment were provided to a total cost of $986.25. Authorizations for X-rays were furnished to a total amount of $792.70.

Below are tabulated figures for the months from September 1936 through April 1937:

State of Rhode Island
Doctors — Prescriptions — Appliances

	Medical	Hospitals
September	$ 4,651.05	$ 2,980.75
October	3,979.37	2,725.68
November	4,045.72	3,073.68
December	4,725.19	3,090.51
January	5,061.59	2,566.18
February	7,723.68	3,075.05
March	8,433.55	3,095.65
April	6,489.22	3,925.60
	$45,109.37	$24,533.10

City of Providence

	Doctors	Hospitals
September	$ 1,657.67	$ 2,060.36
October	1,483.42	2,175.90
November	1,697.89	2,322.16
December	2,303.84	1,850.68
January	3,075.51	2,282.00
February	3,967.62	2,415.00
March	2,952.14	3,043.90
April	2,661.99	2,226.84
	$19,800.08	$18,376.84

	Prescriptions	Appliances
September	$ 396.93	$166.55
October	409.35	124.86
November	470.92	58.17
December	611.91	47.26
January	927.07	69.97
February	1,130.40	92.85
March	703.22	58.85
April	678.59	159.75
	$5,328.39	$778.26

During the months of December, 1936, and January, 1937, through April, 425 men and women were examined by me to determine their eligibility for employment on S.U.R.; at my office in the State Office Building, as well as in the Pawtucket Department of Health, Central Falls Police Station, Rockwell House in Bristol, and my own office. Of this number, 199 were declared ineligible for employment.

Yours very truly,

HENRY J. HOYE, M.D.,
Medical Director.

Providence, May 20, 1937.

Report of the Publicity Committee

At the Annual Meeting of the State Society in June, 1936, the President, Dr. Roland Hammond, appointed the following Publicity Committee for the State Society: Dr. J. W. Leech, Chairman; Drs. R. S. Bray, P. P. Chase, C. Bradley, G. G. Dupre, Stanley Sprague, A. M. Tartaglino, G. L. Young, and J. W. Helfrich. The original purpose of the committee was to abstract scientific papers for the lay press, to serve as a mouthpiece for the medical profession to the press, and to institute propaganda for the enactment of beneficial, and defeat of harmful legislation. In September, 1936, the committee suffered an inestimable loss in the death of the Chairman, Dr. J. W. Leech. During the year various changes were made in the personnel of the committee and after February 1, 1937, it consisted of Drs. C. Bradley, Chairman; P. P. Chase, Providence; G. G. Dupre, Woonsocket; Stanley Sprague, Pawtucket; A. M. Tartaglino, Newport; and G. L. Young, East Greenwich.

During the year the committee submitted to some of the newspapers of the State more complete reports of medical meetings than had previously been available, including abstracts of the scientific papers presented. Considerable data was also obtained from the American Medical Association and from other state medical associations as to their methods of handling publicity. Although several newspapers had been notified that such a committee existed and would be glad to assist in the interpretation of scientific papers for the lay press, no demand was made for this service. No propaganda in relation to medical legislation was handled during the year.

In the spring of 1937 preliminary notices of the State Meeting were broadcast to approximately twenty-five news organs published in the State of Rhode Island. A definite attempt has been made to secure their cooperation and to assure adequate coverage of the 1937 Annual Meeting.

The following points are suggested for the further consideration of the work of this committee:

(1) That the name "Public Relations Committee" would be more in keeping with the terminology adopted by other state societies and would possibly be more in keeping also with the traditions and standing of the State Medical Society than the present name of the committee.

(2) That the committee assist whenever possible in wider and more accurate publicity regarding all meetings of a medical nature including those of district and special societies.

(3) That the committee release periodically during the coming year to all recognized news organs in the State such items of medical interest as would be of educational value to the public and bring desired publicity to the State Society.

(4) The State Committees on Education and Legislation are already supplying very desirable publicity for the State Society and might be assisted in this by the Publicity Committee.

Respectfully submitted,

CHARLES BRADLEY, M.D., *Chairman.*

Rhode Island Hospital

SCHEDULE FOR AUGUST, 1937

Mondays

10:00 A. M. August 2, 16, 30
I Surg. Grand Rounds
August 9, 23
II Surg. Grand Rounds

4:30 P. M. Thoracic Clinic

Tuesdays

9:00 A. M. Gastro-Intestinal Clinic

10:00 A. M. August 3, 17, 31
II Surg. Grand Rounds
August 10, 24
I Surg. Grand Rounds

Wednesdays

10:00 A. M. Tumor Clinic

12:00 noon. Skin Clinic

Thursdays

9:00 A. M. Orth. Grand Rounds

11:00 A. M. Thoracic Clinic

Fridays

11:00 A. M. Fracture Grand Rounds

11:00 A. M. August 6, 20
Pediatric Grand Rounds

11:30 A. M. Heart Conference

7:30 P. M. August 6
G. U. Staff Meeting

8:30 P. M. August 6
Surgical Staff Meeting

Saturdays

9:00 A. M. Neuro. Grand Rounds

10:00 A. M. Medical Conference

Dr. Alex M. Burgess is combining business with pleasure on a trip to England, Scotland, Norway, Sweden, Denmark and Germany. On July 29, at Manchester, he gave a lecture and demonstration of his method of oxygen therapy. He has been asked to give a similar lecture and demonstration

at Edinburgh. Dr. Burgess is accompanied by his wife and his son, recently graduated from Harvard Medical School. His son will remain for six months study of pathology at Innsbruck. Dr. and Mrs. Burgess will arrive home about September 3.

Dr. and Mrs. Herman A. Lawson have a third son, born at the Lying-In Hospital on July 4th.

Dr. Henry Hoye, a member of the Consulting Staff of the Hospital, has been appointed Superintendent of the State Home and School.

Dr. Ralph D. Richardson completed his two years' internship on July 1st and is now acting as Assistant Superintendent for the Summer months. Dr. Richardson is a graduate of Brown University and Harvard Medical School.

On July 1st, Dr. Katharine Knox Cutts terminated her internship in Pathology.

Dr. Edward R. Squier began his dental internship July 1st. Dr. Squier's home is in Providence. He is a graduate of Brown University and Tufts Dental School.

Dr. Charles S. Bryan, of Providence, began his internship June 15th. Dr. Bryan is a graduate of Harvard College and Harvard Medical School.

Dr. Charles Purcell Roberts, of Atlanta, Georgia, and a graduate of Emory College and University, started his residency for one year in Cardiology July 1st. Previous to coming here, Dr. Roberts served as intern at the Peter Bent Brigham Hospital, from October, 1935, to July 1st, 1937.

Dr. Edward B. Medoff has opened an office for the general practice of medicine at Woonsocket, R. I. Dr. Medoff was intern at the Rhode Island Hospital from January, 1934, to January, 1936.

Dr. James Edward Feldmayer started his Pathological Internship July 1st.

Memorial Hospital

A Round Table Conference on various diabetic problems was conducted by the medical service of the Memorial Hospital. It was largely attended by the staff but in particular, there was a large attendance of non-members of the staff from the profession in the Blackstone Valley. The important features brought out at the conference were the care of the comatose patient, proper care of the diabetic on leaving the institution and the care of the diabetic with such surgical complications as carbuncle, gangrene of the feet and abdominal operations such as an appendectomy. A request for another Round Table in the future was made by a number of the medical men in the Blackstone Valley.

Dr. and Mrs. Jesse P. Eddy, 3rd, are to be congratulated on the birth of a second daughter.

Dr. and Mrs. Francis E. Hanley are to be congratulated on the birth of a daughter.

St. Joseph's Hospital

The Annual Outing and Dinner of St. Joseph's Hospital Staff Association was held on June 16, 1937, at the Metacomet Country Club in East Providence, Rhode Island. There were about One Hundred members and guests present. Among the guests were The Most Reverend Francis P. Keough, D.D., Bishop of Providence; Right Reverend Peter E. Blessing, D.D., V.G., and Reverend Thomas C. Collins, representatives of the Hospital Corporation. The afternoon was given over to field sports and golfing, in which a large number of the members participated. There were prizes awarded to the successful entrants in these sports. In the evening, dinner was served at the Club with President Edward F. Burke presiding and Dr. William R. McGuirk toastmaster. Both the Most Reverend Bishop and the Right Reverend Monsignor addressed the gathering. Following the dinner, there was entertainment. Arrangements were in charge of President Edward F. Burke, James H. Fagan and Vincent J. Ryan.

Edwin B. O'Reilly, M.D., C.M., of North Providence, Rhode Island, completed a two year rotating internship at St. Joseph's Hospital on June 30, 1937. He graduated from McGill University Faculty of Medicine, Montreal, Canada, in 1935. Dr. O'Reilly's office will be located at 873 Smith Street, Providence, Rhode Island, after August 1, 1937.

H. Paul Narcessian, D.M.D., of Woonsocket, Rhode Island, completed a one year dental internship at St. Joseph's Hospital, June 30, 1937. He graduated from Tufts Dental College in 1936. He will open an office in Providence sometime in September, 1937.

Stephen Fortunato, M.D., Wilmington, Del., began a two year rotating internship at St. Joseph's Hospital. He graduated from the University of Virginia in June, 1937.

Thomas Anthony Egan, M.D., 154 Francis Street, Providence, Rhode Island, was married in June to Miss Charlotte E. Wendelowski, Floral Park, Long Island, New York. Mrs. Egan is a graduate of St. Catherine's Hospital School for Nurses in Brooklyn.

James J. Flanagan, M.D., 25 Warwick Avenue, Cranston, was married to Miss Loretto Schwartz, of Washington, D. C., on June 15, 1937.

Dr. William Casey, 218 Garden Street, Pawtucket, Rhode Island, began a one year dental internship at St. Joseph's Hospital on July 1, 1937. He graduated from the University of Maryland Dental School in June, 1937.

OBITUARY

EDGAR B. SMITH, M.D., F.A.C.S.

Dr. Edgar Bronson Smith, a leading physician and surgeon of Providence for more than half a century, died suddenly in his bed, of coronary occlusion, in Orlando, Fla., on April 9, 1937. He was on his way to Providence from Clearwater, Fla., where, with his wife, he had spent the winter in the enjoyment of good health.

Dr. Smith was in his eighty-fourth year, having been born in Winsted, Conn., Dec. 23, 1853, the son of Jesse and Jane P. (Bradford) Smith, and came to Forestdale, R. I., with his parents in early boyhood. He prepared for college in Lapham Institute, North Scituate, and entered Brown University with the class of 1878. After a two years' premedical course there, he entered the College of Physicians and Surgeons in Columbia University, obtaining his M.D. degree in 1880. In 1909, by special vote of the Brown University Corporation, he was given his Ph.B. degree and enrolled with the class of 1878. Following completion of his medical studies at Columbia, he returned to Rhode Island to set up a general practice in Providence, but it was not long before he confined himself principally, and later exclusively, to surgery.

Dr. Smith had been visiting surgeon at the Rhode Island Hospital since 1897 and similarly connected with St. Joseph's Hospital from 1898 to 1901. He had also been, up to the time of his death, consulting surgeon to various hospitals in the State, including Butler Hospital.

Dr. Smith was a member of the Providence Medical Association, the Rhode Island Medical Society, the American Medical Association, the American College of Surgeons, the New England Surgical Society, the American Urological Society, the Providence Chemical Club and the Friday Evening Medical Club.

He was married October 12, 1881, to Evelyn O. Bates of this city, who died many years ago. His second wife, Mrs. Harriet Lindsay Smith, whom he married in 1925, is his only survivor.

In the passing of Edgar Bronson Smith, the medical profession of Rhode Island has lost one of its outstanding and most loved members. Not only was he a skillful surgeon who devoted himself without stint to his patients, but a man of the highest character who had endeared himself to the whole people by the charm of his personality. To him might fitly be applied the encomium of our Quaker poet:

> A true and brave and downright honest man;
> Loathing pretense, he did with cheerful will
> What others talked of while their hands were still.

To a bedside he always brought the comfort of a wise, serene and understanding presence; and, figuratively, he was ever busy lighting fires in rooms that called for such warmth and cheer as it might be in his power to produce.

In its sorrowing, this Society remembers these things and much else, and is itself comforted in bereavement.

G. Alder Blumer, M.D.
Lucius C. Kingman, M.D.

FRANK JOSEPH JONES, M.D.

Dr. Frank Joseph Jones died in this city on December 17, 1936, after an illness of 21 months duration. Respected and admired by a host of grateful patients and loyal friends, his passing is mourned by these and countless others who sought his advice, ministrations and friendship. Dr. Jones was born in Worcester, Mass., January 15, 1877, the son of Daniel and Winifred Dolan Jones. He attended public schools. Pursuing his medical course at Harvard Medical School, he was graduated therefrom in 1901 and interned at St. Joseph's Hospital, this city, from 1901 to 1902. He entered practice in this city, settling on Douglas Avenue for the first five years thereof, later moving to Orms Street and finally established himself on Francis Street in 1909, where he remained until illness necessitated retirement from practice, early in March, 1935. He is survived by his wife, Mrs. Alice Kelly Jones and two sons, Frank J., Jr., and Charles, both of whom are teachers in the regional high schools in this city.

Dr. Jones developed a large practice and while never actually specializing devoted a good deal of

attention to obstetrics. He served on the staff of St. Joseph's Hospital as Obstetrician and Assistant Gynecologist for many years. But the chief factor in his establishment was his kindly, sympathetic nature, readily accessible at all times, responsive to all demands, and available for any service. He was really typical of the family doctor one hears so much about in fiction and so little about in real life. These qualities made Dr. Jones so much more desirable as friend, counselor, and intimate adviser. Never spectacular nor dominating, his influence was nevertheless impressed upon those who availed themselves of his services, advice and friendship. To know him was to appreciate those qualities so much to be desired in the daily conduct of a busy practice. He will be missed by a large circle of friends and colleagues but particularly by those of us who were associated with him and bound to him by ties of intimate friendship, and the memory of this steady and constant devotee to the highest ideals of his calling shall serve as an inspiration for many years to come.

JOSEPH L. BELLIOTTI, M.D.,
JOHN J. KENNEY, M.D.

RECENT BOOKS

DIABETES, A MODERN MANUAL. By Anthony M. Sindoni, Jr., M.D. With an Introduction by Morris Fishbein, M.D., and a Foreword by George Morris Piersol, B.S., M.D. pp. 240. Cloth, $2.00, Whittlesey House, McGraw Hill Book Company, Inc., 330 West 42nd Street, New York City, 1937.

This hand-book for the use of patients with diabetes is an excellent example of what a work of this sort should be. It is very clearly written in a style so simple and straightforward that it should be of great value as a guide to any diabetic of average intelligence and ability to read. While there is a great deal of detailed information presented it is done in such a way that the reader is not likely to be confused and the things which are important are easily recognized as such.

The book is divided in three sections. "Questions asked the Physician" is the first. In this are presented in the form of questions and answers most of the material about which a diabetic needs to inquire. The second section, "What to Know," is a very excellent summary of necessary and practical knowledge, with illustrations, diagrams and tables that are helpful and not confusing. "What to Do," the final part of the book, is a very practical discussion of how to act in the various emergencies that may arise, e. g., acidosis and coma, insulin "shock" etc.; and it also includes a discussion of routine activities such as food calculation, exercise, the care of the feet, eyes, bowels, urine testing and so forth. The discussion of general hygiene, the presentation of the methods of food calculation and the section on the care of the feet seem to this reviewer to be especially commendable.

Of course there are a few points on which most internists who are interested in diabetes may differ with the author. It seems to the reviewer that the time recommended for giving insulin (15 or 20 minutes after meals) will find little support among medical men. The locations on the body surface advised for injections are not the sites usually selected. The description of insulin shock in the question and answer section seems quite inadequate, but this is remedied in the fuller description given under "What to Know." On page 187 in the discussion of the treatment of coma in adults no mention is made of giving carbohydrates by mouth. The discussion of Protamine Zinc Insulin is good but, as the author intimates, will require revision very soon as our knowledge of the proper use of this preparation increases.

On the whole it may be said that the flaws that one may detect in the work are insignificant and that the book is deserving of very high praise and can be recommended to the diabetic public (as well as to the general practitioner who wishes to brush up his knowledge of the subject and treat his patients adequately) without reserve.

ALEX. M. BURGESS, M.D.

PHYSICAL DIAGNOSIS, THE ART AND TECHNIQUE OF HISTORY TAKING AND PHYSICAL EXAMINATION OF THE PATIENT IN HEALTH AND IN DISEASE. By Don C. Sutton, M.S., M.D. With 298 Text Illustrations and 8 Color Plates. The C. V. Mosby Co. St. Louis, 1937.

The value of the direct examination of the patient can never be emphasized too strongly. Hence the need of a new approach to the subject is ever present. In this effort, the author has used a few innovations. The most notable is the inclusion of a chapter giving an historical outline of the development of physical diagnosis. Although sketchy, yet it is successful, for it tends to make the reader seek the original work for further details. The subject matter itself is divided up into the examination of the various body parts. The many signs are well described, and the differential diagnosis is on the whole well done. A brief description of the anatomy concerned is also included and this proves to be very helpful. The author in his differential diagnosis is apt to stay afield, however, in giving data that to the reviewer appears irrevelant and unnecessary. For example, in a book of physical diagnosis, there is little need to use eight pages in a discussion of electrocardiographic findings, to give a discussion of X-ray evidence of gastric disease or to give details of procedure in passing a stomach tube, or doing a lumbar puncture. Also his reviewing of diseases is apt to be sketchy and confusing to the reader's mind, rather than instructive. The terminology is generally correct. It is rather amazing, therefore, to find arteriosclerotic heart disease called chronic myocarditis—a phrase that has been declared incorrect for several years. The book is supplied generously with photographs and drawings. The anatomical illustrations are particularly good, honorable

mention being given those of coronal sections. On the other hand to the reviewer, the photographs seemed to be below average. They are not clearly reproduced, and therefore do not demonstrate at all well what the author intends to bring out. They are often strikingly familiar, having appeared in other books before, and carry a quaint old-fashioned character to them. And lastly they are not always germain to the subject up for discussion. This is particularly true in some of the X-rays of conditions that cannot be diagnosed by physical findings, and only seem to be included through general medical interest. The reviewer feels that while there are some excellent points to this book, on the whole better ones are available.

FRANCIS H. CHAFEE, M.D.

AN INTRODUCTION TO MEDICAL SCIENCE. By William Boyd, M.D., M.R.C.P. (Edin.), F.R.C.P. (Lond.), Dipl. Psych., F.R.S. (Canada). Octavo, pp. 307. Illustrated with 108 engravings. Cloth, $3.50 net. Philadelphia, Lea & Febiger, 1937.

The author of this manual requires no introduction. His former authoritative publications have been well received by the Medical Profession. This recent work is really an introduction to Medical Science, and therefore will be of little interest to the physician. However, as an elementary text it will find favor with the student nurse, the pre-medical student, or with the intelligent layman who occasionally becomes "medically minded."

In this book the reader will find a brief but comprehensive survey of disease. The subjects for discussion have been carefully selected, clearly presented, and well illustrated. The nature of the disease process and the relationship between the pathological lesion and the presenting symptoms has been adequately discussed.

Altogether the reviewer found this small volume to be a well written and instructive outline of disease. Offered as an introductory work, it should find considerable favor with those for whom it was intended.

RUSSELL S. BRAY, M.D.

THE INTIMATE SIDE OF A WOMAN'S LIFE. By Leona W. Chalmers. With a Foreword by Winfield Scott Pugh, M.D. pp. 128. Cloth, $1.50. New York, Pioneer Publications, Inc., Radio City, 1937.

This is a non-medical book written by a woman for the edification of women as to their pelvic anatomy and the disturbances that commonly cause trouble therewith. The writer has given chapters as to the anatomy, the common displacements of the pelvic organs and has then discussed the common gynecological symptoms of constipation, leucorrhoea, and menstrual pain.

She has then devoted a chapter to vaginal hygiene and has taken the position that the vagina is a septic cavity which if not thoroughly and painstakingly douched at regular intervals is a breeder of disease and of invalidism. She has shown us various methods of douching, including the most favorable positions and the best type of instruments to use. She has rightly pointed out that most vaginal discharges come from an infected cervix and that there are no glands in the uterine wall which might cause disturbance but that this vaginal wall is drawn into folds and crypts which, unless they are fully distended and washed out, form the lurking places for germs. To overcome this she would overdistend the vagina with her douche solution and thereby get her solution in contact with the depths of the mucosa between the folds. She feels that as with the vagina so with the other body cavities, the mouth, the nose, great care, washing should be carried on.

This is a book that will interest women. It may do some good. One cannot help feel that her method of douching is not a little liable to force the solution up into the uterine cavity and out through the tubes and may not be on that account entirely innocuous. One would also feel that in the presence of a vaginal discharge it were better to consult a competent gynecologist and have the source of the discharge cleared up. We are not yet ready to concede that the vaginal walls are not capable of caring for themselves. It is now known that there is a cycle of the vaginal epithelium which corresponds to that found in the cervix and in the endometrium, and that the acidity of the vagina is in some way dependent on the changes in the vaginal wall and their effect on the vaginal flora. If this is true, is it any more sense to be constantly lavaging and douching out the vagina than to keep constantly gargling or spraying the throat or washing out the nose, all of which procedures are not in favor among good nose and throat people.

In that this book may call attention to women that vaginal discharges are not normal, and get them to consult their doctor, it probably is excellent. We still think that the medical profession is the best judge of how to take a douche and when to take a douche.

GEORGE W. WATERMAN, M.D.

THE NUTRITIVE VALUE OF CANNED FOODS. Compiled by the Nutrition Laboratory, Research Department of the American Can Company. pp. 110, with 10 illustrations and 8 plates. American Can Company, New York, 1937.

The book is a general summary of facts about tin containers and canned foods. It is divided into two sections. The first deals with the preservation of foods, dietary requirements, the mineral and vitamin conservation in canned foods, infant nutrition, and the safety of canned foods under modern methods of packing. Section two takes up the manufacture of the cans, including the tinplating, enameling, and a description of can sizes. It also discusses the canning procedure from the raw materials through the sealing of the cans and the heat processing.

The back of the book contains an appendix of reference tables of all kinds. There are charts on human energy expenditures, dietary requirements, mineral and iodine content of various foods, and analyses of canned foods of many kinds. A bibliography contains an appendix of references to the more complete works on each phase of the industry as well as the general texts used in preparation of the book.